Rituximab Referral Form

BIOHEALTH INFUSION CENTER

www.biohealthic.com | info@biohealthic.com

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ OTHER

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card /Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Hep B Surface Antigen** (within 36 months)
☐ **Hep B Core** (if available)

RITUXIMAB THERAPY ADMINISTRATION: Many payors require patients start therapy with a rituximab biosimilar. Choose ONE of these two options:

☐ Infuse **Rituximab (Rituxan)** OR **Rituximab biosimilar** as required by patient's insurance.

☐ Infuse this **Rituximab** product (subject to prior authorization):
_____
(Products include: Rituxan, Ruxience, Truxima)

Dose: ☐ **1000 mg** ☐ **375 mg/m2** ☐ **500 mg**
Other: _____

Frequency:

☐ **One time dose**
☐ **Day 0, repeat dose in 2 weeks, then repeat course every _____ weeks OR _____ months x _____ months**
☐ **Day 0, repeat dose in 2 weeks**
☐ **Weekly x 4 weeks**
☐ **Every 6 months x _____ months**
☐ **Other** _____

Order is valid for one year unless otherwise noted

Provider Name (Print) **Provider Signature** **Date**

Have a Question? (786)460-6044
Fax Referral Form To: (786)219-3917
8684 SUNSET DRIVE MIAMI FL 33143